DOCKET NO: SA-517
EXHIBIT NO. 16E

NATIONAL TRANSPORTATION SAFETY BOARD
WASHINGTON, D.C.

AFTER ACTION REPORT ON U.S. NAVAL HOSPITAL MCI RESPONSE TO KAL 801 CRASH

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(14 pages)

DEPARTMENT OF THE NAVY
U.S. NAVAL HOSPITAL
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IN REPLY REFER TO:

3440
Ser 011/2054
22 Aug 97

From: Commanding Officer, U. S. Naval Hospital, Guam
To: Commander in Chief, U. S. Pacific Fleet (Attn: Code N01M), 250 Makalapa Drive, Pearl Harbor, HI 96860-7000
Via: Commander U. S. Naval Forces, Marianas (Attn: Code N03), PSC 489, Box 9, FPO AP 96536-0051

Subj: **AFTER ACTION REPORT ON U. S. NAVAL HOSPITAL, GUAM'S MASS CASUALTY RESPONSE TO KOREAN AIR LINES (KAL) FLIGHT 801 CRASH**

Ref: (a) NAVMEDCOMINST 3440.4
(b) USNHGUAMINST 3440.1
(c) Mass Casualty Team Roster for U. S. Naval Hospital, Guam Personnel

Encl: (1) Chronology of Key Events

1. Date of Event 6 Aug 97.

2. Nature of Event: Upon final approach to Guam International Airport Authority runway, KAL flight 801, a Boeing 747-300 aircraft, crashed into Fonte Valley adjacent to Nimitz Hill, during a heavy rainstorm about 3 miles short of the runway. The aircraft skimmed the top of a small hill, then plummeted into a ravine where it slid briefly before impacting against a buttress of land stemming down from a ridge. This impact is likely what caused the plane's fuselage to break apart into 4 sections. Most of the sections burned extensively, while the others remained somewhat intact. To date, the exact cause of crash remains unknown. Refer to enclosure (1) for a detailed timeline of key events.

Of the 254 passengers and crew of the flight, most perished immediately upon impact. Some passengers may have survived the initial impact, but burned to death in the ensuing fire. A few additional persons were able to get away from the burning wreckage, but died soon thereafter from burns/trauma/shock. Over 30 passengers/crewmembers would later be found at the site still alive.

3. Background: Guam is a small tropical island at the border of the Philippine Sea and the Pacific Ocean, measuring about 8 miles wide and 30 miles long. The population is approximately 150,000, which includes about 7,000 active duty military and their dependents. The crash took place on Navy property, but military and civilian emergency rescue personnel worked together at the scene. The crash site was remote and distant from any housing or other buildings/ establishments.

(1)

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4. Emergency Response at the Crash Site.

a. Initial responders at the crash site included Guam Fire Dept., Guam Police Dept., and a U. S. Naval Hospital, Guam (Branch Medical Clinic) ambulance unit, who arrived near the crash site within an hour of the crash.

b. Timely evacuation of the survivors from the scene to either U. S. Naval Hospital, Guam or Guam Memorial Hospital ("survivors" meaning those who were actually evacuated from the scene via helicopter/ ambulance, including those who died later in the hospital) was hampered for many reasons, including:

(1) Emergency teams on duty were quick to respond, however supplemental emergency response support at the scene was delayed due to the early morning time of crash.

(2) There was initial confusion over where the plane went down, and how to access the site. Additionally, the airport did not assume the plane had gone down until 25 minutes after the actual crash, at which time rescue units began receiving notification.

(3) Many physical obstacles, including a locked gate blocking the access road, and a fuel pipeline broken by the impact of the plane, delayed the arrival of initial rescue workers to the scene. Getting from the access road to the crash scene was also quite difficult. To retrieve survivors, rescuers had to carry them across 200-300 yards of steep, muddy terrain, thick with sword-grass, in total darkness.

(4) For the first 1-2 hours upon arrival to the scene, there were more survivors in need of help than the number of rescuers available to assist. Communication between the site and the Emergency Room was practically nonexistent, because the ambulance crew was at the site, far from the ambulance radio. Helicopters and ambulances were used to transport the survivors from the site to the hospitals. The first group of survivors were taken to U.S. Naval Hospital, Guam, and were received at the Triage Site situated adjacent to the Emergency Room approximately 4 hours after the crash occurred. The evacuation process for survivors would continue for the next 2 hours. The crash site was located within 2 miles (straight-line) of U. S. Naval Hospital, Guam, but over 6 miles by road.

5. Response: U. S. Naval Hospital, Guam.

a. Upon confirmation of the airline crash, the Commanding Officer, U. S. Naval Hospital, Guam ordered the recall of all hospital personnel. The Mass Casualty Receiving and Treatment Plan was thus activated (approximately 0300), whereby each staff member mustered on location with their assigned Mass Casualty Team, per reference (b) and (c). The team roster

is updated each quarter to reflect personnel turnover. Mass Casualty Supply Carts were wheeled to designated staging points, and other contingency supplies were off-loaded from the nearby contingency warehouse (e.g. beds, mattresses, linen, litters, IV infusers, thoracic suction units, and syringes, etc.). Some of the muster sites, such as the Delayed Care Team area, were in a "contingency ward" which was rearranged to meet the needs of the impending patient load. The Triage Team mustered and was ready to receive patients by 0405, approximately an hour after the initiation of the command recall.

b. The Helicopter Pad Team began off-loading patients from arriving HC-5 helicopters (CH-46), usually 4 on each helicopter, and transferred them from the Pad to the Triage Site via ambulance.

c. Upon receipt of patients at the Triage Site, the Triage Officer directed the patients to either the Emergency Room, Delayed Care Team, or the Expectant Team. The Emergency Room treated their patients and sent them to either the Expectant Team, Delayed Care Team, Intensive Care Unit, or the Operating Room. The Minimal Care Team was not needed.

d. Requests for personnel from the Manpower Pool (personnel not assigned a specific team) were repeatedly made in order to help with retrieval of supplies, transporting patients, or augmenting one of the potentially shorthanded Mass Casualty Teams. Andersen Air Force Base (36th Medical Group) healthcare providers augmented the Delayed Care Team, which was co-located with the Pre-Op Team. Military personnel from other commands (such as a group of U. S. Navy Seals who had been on their way to the airport) augmented the hospital as well, providing assistance with litter bearing. Korean language interpreters were sent to the various Team treatment centers.

e. Requests were made to CINCPACFLT Surgeon's Office for additional medical help (2 Orthopedic Surgeons, 2 General Surgeons, 2 Anesthetists, 2 Operating Room (O.R.) Nurses, 2 O.R. Techs., and 2 ICU Nurses, in anticipation of a heavy workload for the next few days.

f. Inquiries were initiated to determine where the U. S. Naval Hospital, Guam's 4 severely burned patients should be MEDEVAC'D for follow-on care. Eventually it was agreed they would be sent to Brooks Army Medical Center (BAMC). It was arranged for the burn team from BAMC to fly to Guam, and provide subsequent care on the return flight. In addition, arrangements were made to send 8 stable patients back to Korea. These MEDEVACS were coordinated to include the additional survivors at Guam Memorial Hospital. Eventually, a New Zealand native was MEDEVAC'D back to his country. The remaining survivors were Guam residents who would remain at U. S. Naval Hospital, Guam until discharge.

g. The SPRINT team was sent to Guam from NAVMEDCEN San Diego to conduct debriefings for personnel from all participating commands who would be involved in response efforts.

h. Overall, U. S. Naval Hospital, Guam received 19 survivors throughout the morning of 6 Aug, including 1 who was pronounced DOA, 1 who was designated "expectant" (who died at noon), and another who died later that afternoon in the ICU. Guam Memorial Hospital received 13 patients overall.

6. Participants (both initial and subsequent). U. S. Naval Hospital, Guam, HC-5, USS Frank Cable, USS Honolulu, Seabees from NMCB 133 and 44, Burn Medical Teams from Brooke Army Medical Center and Wilford Hall AFB, COMNAVMAR, U. S. Navy SEALS, U. S. Navy Reserve Fleet Hospital 21, U. S. Naval Dental Clinic, NCTAMS, NAWMU-1, Modified Medical Response Teams from Tripler Army Medical Center and U. S. Naval Hospital, Yokosuka, X-ray support from NAVMEDCLINIC Hawaii and the 121st EVAC Hospital, Korea, General Duty Corpsman support from NAVMEDCEN San Diego CA, Naval Hospital, Camp Pendleton CA, and Naval Hospital, Bremerton WA, Guam International Airport Authority, Korean Airlines, the U. S. Coast Guard, Guam Police Dept, Guam Fire Dept, Civil Defense, Guam Public Health Dept, Guam Memorial Hospital, Anderson Air Force Base 36th Medical Group, National Transportation Safety Board, FBI, and perhaps a few other agencies/units not realized at this time.

7. Preparation. U. S. Naval Hospital, Guam conducted an all-hands Mass Casualty Exercise, simulating an airline crash, in April 1997, jointly with other Government of Guam agencies. U.S. Naval Hospital, Guam conducts training quarterly (either a command wide exercise, or training at the local Team level, alternating each quarter).

8. Aftermath. U. S. Naval Hospital, Guam received additional follow-up tasks from COMNAVMAR, to assist in the aftermath of the crash as follows:

a. The Radiology Dept. was assigned to assist in the identification of remains at the Forensic Identification Site, a pier-side warehouse at COMNAVMAR, by taking X-ray photographs of all human remains from the crash site.

b. Members of the Dental Dept. volunteered for duty at the Forensic Identification Site, to assist in identification of remains through dental X-rays.

c. Additional working parties were required at the Forensic Processing Site to assist with handling of the remains through other sections at this site, including Photography, Pathology, Forensic Anthropology, Personal Effects, Embalming, Fingerprinting, etc.

d. Medical personnel were assigned responsibility for removing all human remains from the plane wreckage. EMT personnel and a Medical Officer were assigned to provide medical care at the crash site in the event of workers succumbing to heat illnesses or other injuries.

e. To meet this large demand for manpower, 15 X-ray Techs, a Radiologist, 10 EMTs, and 40 general duty corpsman were requested from BUMED via CINCPACFLT.

f. As of this time (21 Aug 97, over 2 weeks since the time of crash), it is estimated that body extraction from the crash site will continue for only a few more days. The efforts there have been hampered by extremely bad weather. The forensic identification process is expected to continue for up to a few more months. The requirement for U.S. Naval medical support at the Crash and Forensic ID sites is diminishing, and should cease within a week or two.

g. The SPRINT team, along with support from U.S. Naval Hospital Guam's Mental Health Dept. has worked feverishly to ensure all personnel involved (from all commands) receive debriefings upon completion of their disaster support efforts. No person is allowed to leave Guam without first receiving the debriefing.

9. Lessons Learned. The KAL FLT 801 crash challenged all agencies/units involved. Lessons learned from this event will help strengthen U. S. Naval Hospital, Guam's ability to react to future emergency response situations. The staff of U. S. Naval Hospital, Guam demonstrated a high degree of professionalism and teamwork in response to the crash, and were able to improvise as necessary to meet the demands placed upon them.

One week after the crash, an After Action Debrief was scheduled, whereby each Mass Casualty Team Captain and key Dept. Heads brought performance improvement feedback to share with other members of the meeting. The following are notable areas of concern, and include recommendations for enhancements to existing procedures and practices. Necessary changes will be included in a forthcoming edition of Ref (b).

a. Medical Response Team. The first few hours following the crash were crucial; it was noted by a crew member of HC-5 (a flight surgeon) that additional medical support at the scene may possibly have helped save lives. The exchange of quality information between the crash site and the hospital, and the availability of added expertise at the site, would enhance the overall medical support.

Recommendation: The U. S. Naval Hospital, Guam Medical Response Team shall be identified as "first" on the hospital recall and will be deployed to the scene of a mass casualty to expeditiously assist with medical regulating, communication, triage support, and litter bearing, as necessary.

b. Mass Casualty Team Supply Carts. A shortage of medical supplies (e.g. IV fluids, minor procedure kits, oxygen, etc.) were noted in various patient care areas. Supply runners were tasked with gathering necessary supplies from Materials Management Dept., and from borrowing from other care areas throughout the hospital. In recent months, a list of supplies necessary for the adequate stocking of Mass Casualty Supply Carts was placed on order in accordance with input from individual Mass Casualty Team Captains/Supply Petty Officers. Unfortunately, there was no funding for the items until it was too late for them to be available for the casualty.

Recommendation: Required items identified will be stocked and maintained in their appropriate Mass Casualty Team Carts upon receipt. Supplies will be rotated out 9 months prior to expiration using an exchange system with the Supply Dept.

c. Recall System. Many staff members, including some of the CO/XO Special Assistants, did not receive calls in a timely manner, and some not at all. The existing SOP at the Chief of the Day's desk did not provide the duty crew with sufficient guidance for conducting a rapid recall.

Recommendation: The recall SOP shall be reviewed and updated as necessary for use by the Chief of the Day duty crew, to ensure timely notification. Specifically, guidance will be provided for use by all key members of the recall bill. Each Director (including XO/CO) shall have 2 alternate, designated individuals listed in the recall bill who will perform the departmental recall for them in their absence. In turn, each Dept Head shall have 2 alternate, designated individuals to do the same at the Departmental level. The monthly Departmental recall roster updates shall now be routed through respective Directors instead of going straight to POMI/Chief of the Day's desk. The Directors should ensure they have a complete recall roster with them at home.

d. Mass Casualty Team Roster. Updated quarterly, this roster does not always keep up with sudden, high turnover periods, such as in the Summer months. This may end up resulting in a few Mass Casualty Teams being deficient of key personnel during a casualty. This fact was identified because some of the new MC and NC officers looking for something to do during the casualty were specialists who would have been valuable assets to specific teams.

Recommendation: Key personnel shall be assigned a Mass Casualty Team upon check-in to the Command, rather than waiting until the next quarterly roster update. This will be done by putting them on the same team as the person they are likely replacing.

e. Communications. Upon initiation of the Mass Casualty Receiving and Treatment Plan, Team Captains have been instructed to retrieve hand held radios at the Chief of the Day's

desk. However, everyone is instructed that telephones should be the first and preferred method of communication. During this casualty, there were not enough radios to go around. Some of the Team Captains needed radios more than others, but did not get them. Additionally, the hospital needs to be in communication with the scene and incoming helicopters. We were not on the same frequency with incoming HC-5 helicopters.

Recommendation: Radios shall be labeled for who they should be distributed to during a casualty (real or exercise), ensuring the key players as well as the remote, outdoor teams such as Helo Pad and Triage receive radios. Additional radios shall be put on order. Additionally, cell phones should be distributed for use by the Medical Response Team deployed to the site, and to any other remote operations with a crucial need. It is suggested that the hospital adopt a specific, separate radio frequency which will put the Emergency Room and Helo Pad Landing Team in contact with HC-5 helicopters.

f. Command Post. There was a cluster of people at the Command Post (Chief of the Day's desk) migrating in and out, coupled with a tremendous amount of phone calls, inundating the Command Post members' communication tasks.

Recommendation: Command Post personnel should utilize office phones of adjacent spaces for making outgoing calls when possible, leaving the common-known Command Post phone lines free for incoming calls. The PAO, Commanding Officer, etc. should conduct business and public relations in the Tricare Enrollment Office (adjacent to the Chief of the Day desk) in order to prevent interference with Command Post operations.

g. Assigned Muster Sites. The Mass Casualty Team Roster indicates the location for all muster sites. Many people fortunately made the decision to report to the E.R. to await initial arrival of patients, because that is where the action would commence. These same individuals can follow the patients from the Triage/E.R. area to their assigned area of care accordingly.

Recommendation: Upon reporting to respective muster sites, a few select personnel from key treatment areas such as surgery, anesthesia, radiology, lab, x-ray, etc. should be temporarily routed to the E.R. to await incoming patients, augmenting the E.R./Triage Team staff.

h. Continuation of Care/ Follow-up Tasks. In the confusion of a real Mass Casualty, key players often become caught up in their local spaces Broad spectrum communication between these important individuals is important both in the short and long run. Among key concerns throughout the KAL FLT 801 disaster support efforts, both initially and during the aftermath, was the issue of manpower, equal division of labor (specifically in regards to shift-work assignments at the Sites and the extra help needed by the hospital duty crews during the

first week following the casualty), and proper designated provider-patient responsibility.

Recommendation: Periodic briefs shall be scheduled by the CO or XO to include the Directors, chief surgeons, Nursing Services, Patient Administration, and other key personnel/providers, so that vital information is shared and kept up to date. Staffing strategies for the command should be worked out in advance so that the first few crucial days of patient care are covered efficiently. To justify augmentation of our staff by additional off-island personnel, all U. S. Naval Hospital, Guam personnel should be rotated into a continuous shift-work schedule until the workload decreases back to normal. The duty crew will need additional watchstanders to help with phones and driving for the first 4-5 days following a mass casualty event of this magnitude..

i. Joint Supply/Personnel Issues. During the aftermath of the casualty, COMNAVMAR assumed Command and Control of the crash site. Numerous supply/personnel requests were initiated at the scene and forwarded to randomly selected individuals without appropriate representatives from various Commands (involved in support during the aftermath) being given a chance to jointly take these requests for action. This resulted in duplication of efforts and erroneously canceled orders.

Recommendation: Participating Commands need to have a representative at daily briefings held at Command and Control Headquarters, whose duties shall include jointly coordinating any action taken regarding supply and personnel requests.

j. Security. Normally, U. S. Naval Hospital, Guam is an open base with no gate guard. During Mass Casualties, the gate is manned by Security to limit access to military personnel, representatives of supporting agencies, and family members of patients. The Commanding Officer may authorize access to the press if he wishes. During the KAL FLT 801 casualty, demand for security exceeded our capabilities, specifically regarding premature access of the press and family members into the hospital. Local members of the Auxiliary Security Force were recalled to perform duties at the crash scene, so were unavailable for use at the hospital.

Recommendation: The Security Dept. should be augmented by additional personnel from the manpower pool in order to assist with both gate and internal hospital security.

k. Transportation. Many simultaneous supply and personnel requests from various teams require the use of duty vehicles for retrieval and shipment. Assignment of duty vehicles during the casualty was not a centralized process.

Recommendation: All Command transportation assets shall be controlled and administered from the Command Post.

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1. Location of Family Member Gathering Center. The location was in the Chapel, right across the street from the Triage Area and Expectant Area.

Recommendation: Move the location to the J-1 Command Conference Room or Auditorium so that it is out of the line of sight of the Expectant and Triage Areas.

10. Concluding Observations. Some of the unique characteristics of this particular disaster provided a challenge for U.S. Naval Hospital, Guam personnel, and should be noted for future reference.

a. Language barrier of predominantly Korean passengers

b. Enormous press interest presented a security challenge.

c. Complexity of dealing with both domestic and foreign-national State Departments regarding MEDEVAC routing.

d. Handling of all victim's relatives who were allowed to converge at the U. S. Naval Hospital, Guam Chapel to await word on survivors. The Chaplain was initially overwhelmed with the numbers, but was soon aided by COMNAVMAR Chaplains and the hospital's Mental Health Dept.

e. Handling of all patient valuables.

f. Identification of survivors was sometimes ackward because names provided by interpreters brought to the hospital differed from what was listed on the flight manifest. The CHCS disaster program (using numbers instead of names for patient I.D.) helped to prevent potential medical care-related problems.

g. A Memorandum of Understanding between a military MTF and local civilian hospitals should exist which would allow for courtesy privileges extended to civilian healthcare providers to assist at a military MTF as consultants in event of casualties of a large magnitude.

h. Reimbursement of expenditures incurred by external cost centers, such as the Fleet Hospital 21 warehouse which was opened up in this case to provide additional litters and body bags to the crash site during the aftermath.

11. Conclusion. As of the time of this writing, the KAL FLT 801 disaster support efforts by the staff of U. S. Naval Hospital, Guam continues. Additions to this report may be forthcoming as the support efforts come to a close in the next few weeks. U. S. Naval Hospital, Guam

personnel performed in an exemplary and highly professional manner throughout the casualty. All the training in the world cannot adequately prepare a unit such as U. S. Naval Hospital, Guam to handle a scenario such as the KAL FLT 801 incident flawlessly. But having now been through a real-life scenario, U. S. Naval Hospital, Guam personnel now qualify as "experts."

DAVID L. WHEELER, SR.

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Korean Airlines Flight 801 Crash and the U. S. Naval Hospital Guam Response

8/6/97	0142	Korean Air Flight 801 crashed in the Nimitz Hill area.
8/6/97	0227	Navy Auxiliary Security Force personnel arrived at the crash site
8/6/97	0229	U.S. Naval Hospital (USNH), Guam, was notified of a possible downed aircraft.
8/6/97	0240	USNH was notified of a confirmed downed aircraft. Mercy 1 was dispatched to the crash site.
8/6/97	0242	The Commanding Officer, Captain David Wheeler was notified of a downed aircraft.
8/6/97	0250	The Commanding Officer reported onboard USNH
8/6/97	0300	The Hospital's Disaster Recall Plan was placed into effect.
8/6/97	0315	Arrival of staff begins.
8/6/97	0340	Manpower Pool established in the galley.
8/6/97	0400	The Chaplain and Mental Health staff established and manned the family support center inside the chapel. Blood Bank Trauma team onboard. They began deglycerolizing frozen blood.
8/6/97	0415	Approximately 80% of the Hospital's Military staff were onboard and ready to receive casualties. All Disaster carts had been distributed. Supply did a walk through and received supply requisitions for all wards and the ER.
8/6/97	0530	The first Helicopter arrived with 2 patients onboard. Supply notified 36th Medical Group to standby for emergency supply requests for Medical/Surgical items. The Galley opened early to serve meals. Galley staff delivered water, sandwiches and fruits to the various sites and disaster stations.
8/6/97	0545	Supply coordinated the transfer of needed IV fluids to and Silvadene cream from GMH.
8/6/97	0550	Spriht, Medical, and Surgical support teams placed on alert by BUMED.
8/6/97	0600	Ambulance arrived with 2 patients aboard. Supply initiated an emergency requisition of 300 cases of Lactated Ringers from FISC Guam. Eighteen units of Frozen Blood (9 O+ and 9 O-) were deglycerolized and ready for transfusion.
8/6/97	0615	Mercy 1 arrives with 2 patients aboard. Supply picked up the 300 cases of Lactated Ringers and distributed the first 30 cases.
8/6/97	0620	Ambulance arrived with 2 patients aboard. Volunteers arrived from the USS Frank Cable for the Manpower pool.
8/6/97	0630	Helicopter arrived with 2 patients onboard. Forty litters were transported to the crash site via stakebed truck. Mercy 1 returns to crash site.
8/6/97	0635	Ambulance arrived with 1 patient aboard.
8/6/97	0655	Helicopter arrived with 4 patients onboard.
8/6/97	0700	Volunteers arrived from COMNAVMAR, AAFB and NDC for the Manpower pool.
8/6/97	0715	Helicopter arrived with 2 patients onboard.

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8/7/97	1105	CCATT (3 MC, 4 Rn, 2 RT) arrived . Burn Team (1 PAO(civilian), 2 Gen Surg, 2 NC, 3 Med techs, 2 RT, 1 Lab tech (civilian) 1NCOIC) from BAMC arrived NH Guam
8/7/97	1230	Medevac Patient charts were copied.
8/7/97	1430	Patient T-2 was returned to the OR for redebridement of wounds Completed at 1630.
8/7/97	1745	The eight patients were loaded aboard the Medevac bus and transported to Anderson AFB (AAFB).
8/7/97	1940	Medevac Bus arrived at AAFB and the patients were transferred to the awaiting C9 aircraft.
8/7/97	2100	C9 Medevac aircraft departed for Korea.
8/8/97	0155	Patient T-5 brought to OR. Underwent Exploratory Lap, and thermodilution catheter placement. Completed at 0520.
8/8/97	0735	Notification was given requesting the Medevac of twelve additional patients from Guam Memorial Hospital to the Inha University Hospital in Korea.
8/8/97	0753	Patient T-17 brought to OR. Underwent I&D of Rt Tibia and Rt tibia rod placement. Completed at 1055.
8/8/97	1300	X-Ray film processor installed at Morgue site by BMET's.
8/8/97	1600	USNH personnel arrived at GMH and loaded the twelve patients aboard the Medevac bus for transport to AAFB.
8/8/97	1830	Medevac Bus arrived at AAFB and the patients were transferred to the awaiting C9 aircraft.
8/8/97	2000	C9 Medevac aircraft departed for Korea.
8/9/97	0700	X-Ray staff (1 Radiologist & 3 Techs) begin the daily task of supporting temporary mortuary site.
8/9/97	0800	Approval was given by LCDR Widergren for the transport of the four patients to the Brooke Army Medical Center (BAMC) in Texas.
8/9/97	0845	Working party of approximately 7 pers assisted in restoring B2 to previous state.
8/9/97	0930	The four patients were loaded aboard the Medevac bus and transported to Anderson AFB (AAFB). CCATT (3 MC, 4 RN, 2 RT), Burn Team (1 PAO(civilian), 2 GenSurg, 2 NC, 3 Med techs, 2 RT, 1 Lab tech (civilian) 1NCOIC) departed NH Guam on MEDEVAC to Brooks Army Medical Center, TX
8/9/97	1045	Medevac Bus arrived at AAFB and the patients were transferred to the awaiting C141 aircraft.
8/9/97	1400	C141 Medevac aircraft departed for Texas.
8/9/97	2140	2 Xray techs from NAVMEDCLINIC Pearl Harbor arrived.
8/9/97	2230	2 Xray techs from NH Yokosuka arrived. 2 Xray techs from 121st Evac Hosp Seoul arrived.
8/10/97	0100	NAVMEDCEN San Diego Sprint team (7 pers) arrived at USNH.

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8/10/97	0700	X-Ray staff (1 Radiologist & 3 Techs) transported to support the temporary mortuary site.
8/10/97	0900	Portable x-ray units were requested from Tripler AMC for Morgue site use.
8/10/97	1600	Approval was given by LCDR Widergren for the transport of the patient to New Zealand.
8/10/97	2355	The patient was loaded aboard the Medevac Ambulance and transported to Anderson AFB (AAFB).
8/11/97	0045	Medevac Ambulance arrived at AAFB. Patient was maintained on the flight line awaiting final approval from the U.S. Government.
8/11/97	0300	Patient was transferred back to USNH.
8/11/97	0400	The patient was loaded back aboard the Medevac Ambulance and transported to Anderson AFB (AAFB).
8/11/97	0440	Medevac Ambulance arrived at AAFB and the patient was transferred to the awaiting C9 aircraft.
8/11/97	0530	C9 Medevac aircraft departed for New Zealand.
8/11/97	0700	20 staff from USNH provided to temporary mortuary site as "trackers". X-Ray staff (1 Radiologist & 3 Techs) transported to support the temporary mortuary site.
8/11/97	1100	A second X-ray film processor was installed at Morgue site by BMET's.
8/12/97	0700	23 staff from USNH provided to temporary mortuary site as "trackers". X-Ray staff (1 Radiologist & 3 Techs) transported to support the temporary mortuary site.
8/12/97	2355	NH Bremerton personnel (13 Gen Duty HMs and EMTs) arrived.
8/13/97	2040	(4) NH Camp Pendelton personnel arrived.
8/13/97	2155	(9) NH Camp Pendelton personnel arrived.
8/14/97	0700	19 staff from USNH, NH Camp Pendleton, and NH Bremerton provided to temporary mortuary site as "trackers". X-Ray staff (1 Radiologist & 3 Techs) transported to support the temporary mortuary site
8/14/97	1200	The portable x-ray units requested from Tripler AMC were received, calibrated and installed by BMET's.
8/15/97	0244	(2) NMCSD Sprint Team members arrived to replace the 2 members that deployed with the USS Frank Cable.
8/15/97	0700	19 staff from USNH, NH Camp Pendleton, and NH Bremerton provided to man the Crash site Medical tent / remains recovery and 20 personnel provided to the temporary mortuary site as "trackers" X-Ray staff (1 Radiologist & 3 Techs) transported to support the temporary mortuary site
8/15/97	1730	(30) NAVMEDCEN San Diego personnel arrived.
8/16/97	0700	20 staff from USNH and NMCSD provided to man the Crash site Medical tent / remains recovery and 20 personnel provided to the temporary mortuary site as "trackers". X-Ray staff (1 Radiologist & 3 Techs) transported to support the temporary mortuary site

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8/17/97	0700	20 staff from USNH and NMCSD provided to man the Crash site Medical tent / remains recovery and 20 personnel provided to the temporary mortuary site as "trackers". X-Ray staff (1 Radiologist & 3 Techs) transported to support the temporary mortuary site.
8/17/97	1300	2 Xray techs from the 121st Evac Hospital in Seoul departed for parent command.
8/18/97	0700	20 staff from USNH, NH Camp Pendleton, and NH Bremerton provided to man the Crash site Medical tent / remains recovery and 20 personnel provided to the temporary mortuary site as "trackers". X-Ray staff (1 Radiologist & 3 Techs) transported to support the temporary mortuary site.
8/19/97	0700	20 staff from USNH, NMCSD, NH Camp Pendleton, and NH Bremerton provided to man the Crash site Medical tent / remains recovery and 20 personnel provided to the temporary mortuary site as "trackers". X-Ray staff (1 Radiologist & 3 Techs) transported to support the temporary mortuary site. 2 Duty Drivers and 1 Biohazard waste disposal person added to the duty schedule.